

AMENDATORY SECTION (Amending WSR 98-24-121, filed 12/2/98, effective 1/2/99)

WAC 296-15-001 Definitions. (1) "Substantially similar"
(~~(means)~~):

~~((1))~~ (a) The text of the department's document has not been altered or deleted; and

~~((2))~~ (b) The self-insurer's document has the text:

~~((a))~~ (i) In approximately the same font size;

~~((b))~~ (ii) With the same emphasis (bolding, italics, underlining, etc.); and

~~((c))~~ (iii) In approximately the same location on the page as the department's document.

(2) "Third-party administrator": An entity which contracts to administer workers' compensation claims for a self-insured employer.

(3) "Claims management entity": All individuals designated by the self-insured employer to administer workers' compensation claims, including self-administered organizations and third-party administrators.

AMENDATORY SECTION (Amending WSR 99-23-107, filed 11/17/99, effective 12/27/99)

WAC 296-15-021 (~~(Individual firm self insurance application.)~~) Self-insurance certification requirements and application process. (~~((1) What does individual firm mean when applying for certification to self insure workers' compensation benefits?~~ When applying for certification to self insure workers' compensation benefits, an individual firm means a sole proprietor, partnership or corporation which is responsible for its own audited financial statements.

~~((2) What minimum requirements must an individual firm meet to apply for self insurance certification?~~ The department will consider an individual firm's application for self insurance certification if it:

~~(a) Meets the department's net worth requirement;~~

~~(b) Has been in business for three years; and~~

~~(c) Has acceptable accident prevention programs in place for at least six months in Washington locations.~~

~~((3) How does an individual firm apply?~~ The individual firm

~~must submit Self Insurance Application SIF 1 L&I form F207-001-000 and three years of financial statements with the most recent year's financial statement audited by a certified independent public accountant.~~

~~(4) What happens after an individual firm submits its application to the department?~~ After the department receives an application from an individual firm, the department will:

~~(a) Conduct an evaluation of the written accident prevention program in effect at a sample of the applicant's locations;~~

~~(b) Consider all matters related to the application; and~~

~~(c) Notify the individual firm whether certification is approved or denied thirty days before the requested certification date unless more time is needed.~~

~~(5) What if the application is denied?~~ The application will be denied if the individual firm does not meet the department's financial and/or accident prevention program requirements. If the application is denied for:

~~(a) Financial reasons, the individual firm may reapply after its next independently audited financial statement is available. The department may require the applicant to provide additional information.~~

~~(b) Accident prevention program deficiencies, the individual firm may be required to wait six months before reapplying.~~

~~(c) Both financial reasons and accident prevention program deficiencies, the individual firm may reapply after its next independently audited financial statement is available. The department may also require the applicant to wait six months before reapplying.~~

~~(6) What if the application is approved?~~

~~(a) If the application is approved, the individual firm must do all of the following before certification will be granted:~~

~~(i) Provide written acknowledgment L&I form F207-144-000 of its responsibility to pay benefits on all claims incurred during its period of self insurance. This obligation will continue even if the individual firm voluntarily or involuntarily surrenders its self insurance certification.~~

~~(ii) Provide surety in the amount determined necessary by the department. Surety must be filed with the department on a form provided by the department. Initial surety will be the greatest of:~~

~~(A) The minimum surety. This amount is calculated annually by department actuaries and is equal to the projected average current cost of a permanent total disability claim, including time loss, pension reserve and other claim costs paid prior to pension.~~

~~(B) The estimated annual amount of accident fund and~~

~~medical aid fund premiums the self insurer would have paid if still in the state fund.~~

~~(C) The estimated amount of developed incurred benefits based on the self insurer's past experience with state fund adjusted for changes in the benefit schedules and exposure.~~

~~(D) The estimated average annual incurred losses made by an independent qualified actuary and accepted by the department.~~

~~Surety will never be established at a level lower than the minimum surety amount. The department may increase the initial surety amount if other conditions are expected to alter the potential claim costs and/or the self insurer's ability to pay them. A decrease will not be considered during the first three years of certification.~~

~~(iii) Pay its share of any state fund deficit or insufficiency. See the Employer's Guide to Self Insurance L&I form F207-079-000 for how the deficit share is calculated.~~

~~(iv) Obtain the services of an individual or service organization with an individual qualified to administer a Washington workers' compensation program.~~

~~(A) A qualified claim administrator has satisfactorily demonstrated to the department:~~

~~(I) A thorough knowledge in Title 51 RCW and all workers' compensation rules; and~~

~~(II) An expertise in claim adjudication.~~

~~(B) The claim administrator must also have the authority to make prompt:~~

~~(I) Payment of all compensation and assessments when due; and~~

~~(II) Decisions regarding claim adjudication and awards.~~

~~(C) If a service organization will be used, submit a copy of the service contract.~~

~~(I) The contract copy may delete clause(s) relating to payment of services.~~

~~(II) However, if payment for services is based on the number of claims filed by the self insurer's workers, this must be explained in detail. The department may require an unaltered copy of the agreement for clarification.~~

~~(b) The self insured individual firm will be held accountable for:~~

~~(i) Its entire workers' compensation program, including all actions on its claims, regardless of whether it contracts with a service organization or administers its own program; and~~

~~(ii) Complying with and keeping informed of all changes to industrial insurance laws and rules.~~

~~(c) Certification of an individual self insurer will include all of its subsidiaries (fifty percent owned and/or financial interest controlled by) or divisions doing business in Washington. One certificate will be issued to an approved self insurer. The subsidiaries or divisions will be considered one~~

~~self insurer for all industrial insurance purposes.~~

~~(d) The effective date of certification will be the first day of the quarter after the department receives the surety and required documentation. If the applicant fails to provide the required information before the approved certification date and later wishes to follow through, the department will require the individual firm to reapply.~~

~~(7) What if an individual firm is a subsidiary of a corporation?~~

~~(a) If an individual self insured firm has a parent (owner of fifty percent and/or having controlling financial interest), the parent must provide the department with its written guarantee L&I form F207 040 000 to assume responsibility for all workers' compensation liabilities of the subsidiary if the subsidiary defaults on its liabilities.~~

~~(b) If a parent fails to provide a guarantee, the department will require the subsidiary to provide surety at one hundred twenty five percent of its actual requirement. The subsidiary must continue to provide surety at the higher level as long as it has no parental guarantee.))~~

(1) What requirements must an employer meet to apply for self-insurance certification?

An employer must meet all the following minimum criteria:

(a) Be in business for three years prior to applying for self-insurance.

(b) Have a written accident prevention program in place in Washington state for at least six months prior to making application.

(c) Have total assets worth at least twenty-five million dollars as verified by audited financial statements prepared by independent certified accountants.

(d) Demonstrate positive earnings in the current year and two out of the last three years. The overall earnings for the last three years must also be positive.

(e) Have a current liquidity ratio of at least 1.3 to 1, and a debt to net worth ratio of not greater than 4 to 1.

(2) When are applications processed? The department processes applications for certification the quarter after the application is accepted. Self-insurance certification for approved applicants will be effective the quarter following processing.

(3) What documentation must be submitted with an application? The following documentation must be submitted with each self-insurance application:

(a) A completed application form (Form F207-001-000) with a nonrefundable application fee. The application fee is reviewed annually by the department and is based on the administrative costs incurred in processing an application, but in no instance will it be less than two hundred fifty dollars.

(b) Three years of audited financial statements prepared by

independent certified accountants. The audited financial statements must be in the name of the applicant.

(c) A list of all of the applicant's physical locations and addresses in Washington state, including all subsidiary operations.

(d) A copy of the written accident prevention program for each of the applicant's operations in Washington. If the applicant or any of its subsidiaries has multiple locations, more than one copy of the accident prevention program may be required.

(e) A completed Self-Insurance Certification Questionnaire (Form 207-176-000).

(4) What happens during the application review process?
The department:

(a) Assesses the accident prevention program at department-selected sites.

(b) Analyzes the financial information supplied by the applicant. The department may also consider relevant information obtained from other sources to assess the applicant's financial strength.

(c) Reviews the completed Claims Administration Questionnaire and attachments. Additional information may be requested.

The department determines whether the application is denied or tentatively approved. The department notifies each applicant of its decision. If the department denies an application, it will state the reasons for the denial in its notification.

(5) If the application is denied, when may the applicant submit a new application? If an application is denied for deficiencies in its accident prevention program, the applicant may submit a new application for certification after the corrections to the program are made and have been in place for six months.

If the application is denied for financial reasons, the applicant may submit a new application for certification after the next annual audited financial statement is available.

If the application is denied because the claims administration organization is deficient, the applicant may submit a new application for certification after corrections to the program are made.

(6) What if the application is tentatively approved? The applicant must submit the following:

(a) Surety in the amount determined by the department and issued on the department form.

(b) A signed copy of the service agreement with a third-party administrator, if applicable.

(i) The contract copy may delete clauses(s) relating to payment of services.

(ii) However, if payment for services is based on the

number of claims filed by the self-insurer's workers, this must be explained in detail.

(c) A copy of any excess insurance (reinsurance) policy including Washington state endorsements, if obtained.

(d) A signed copy of the Acknowledgement of Self-Insurance Responsibilities form.

(e) Payment of any outstanding premium of the applicant's state industrial insurance account.

(f) Payment of the applicant's estimated portion of the deficit, if a deficit condition in the state industrial insurance fund exists at the time of application.

If the required items are not received prior to the end of the quarter, the application may be denied. If the application is denied, the applicant must reapply in order to be considered for self-insurance.

(7) How is the initial surety requirement established? The initial surety requirement is established at the highest of the following:

(a) The annual premiums the applicant pays (or would pay) into the state industrial insurance fund; or

(b) The annual average of the last five years of developed incurred costs to the state industrial insurance fund; or

(c) The minimum surety requirement as established annually by the department. The minimum surety requirement is equal to the average total cost of one permanent total disability award.

The applicant has the option of submitting an independent actuarial analysis of its projected liability. The department reserves the right to accept or reject this analysis. In no event will the surety requirement be established at less than the minimum surety in force at that time.

NEW SECTION

WAC 296-15-024 Additional certification requirements. (1)
What if the employer is a joint venture? A joint venture is defined as two or more employers that have signed a contractual agreement to operate as a single unit for a specified period of time for the completion of a specific task. The department will consider a joint venture's application for self-insurance if the joint venture is sponsored by a current self-insurer.

In addition to the standard certification requirements found in WAC 296-15-021, an application from a joint venture must include:

(a) The name of a sponsoring party. The sponsoring party must be a certified self-insurer in good standing with the

department and have a majority financial interest in the assets and profits of the joint venture.

(b) A list of named participants. Each named participant must also:

(i) Demonstrate that it has at least twenty percent interest in the joint venture.

(ii) Submit three years' worth of audited financial statements prepared by certified independent accountants.

(c) A written acknowledgement from each named participant of its joint and several liability for continuing compensation if any participant of the joint venture defaults. This responsibility continues until the department grants a written release to the joint venture or the remaining participant(s) of the joint venture. A written release from the department is granted only after the contract has been completed and a final settlement of the joint venture account has been made.

(d) A written description of the obligations of each participant for the industrial insurance program of the joint venture.

(e) A written acknowledgement of the sponsoring party's responsibilities for the management of all claims and payment of all compensation incurred during the period of the joint venture's self-insurance certification and after the joint venture is dissolved. This acknowledgement must include the sponsor's continuation of benefits if the joint venture or any of the other parties of the joint venture defaults.

(2) **What if the employer is an employee stock ownership program (ESOP)?** An employee stock ownership program is defined as a firm in which the employees have purchased a majority of the financial interest.

If the employees purchase an existing self-insured company, that company would be required to return to the state industrial insurance fund for a minimum of one year before the department would consider its application for self-insurance.

(3) **What additional requirements exist if the employer is a group?** A group is defined as a group of employers authorized under chapter 51.14 RCW to form self-insurance groups.

(a) In addition to the standard certification requirements found in WAC 296-15-021, an application from a group must include:

(i) A copy of the group's bylaws.

(ii) Individual applications for each of its members along with the current audited financial information of each member.

(iii) A current audited consolidated financial statement of the group (if the group exists at the time of the application).

(iv) A listing of the estimated standard premium to be developed for each member individually and the estimated standard premium of the group as a whole.

(v) An indemnity agreement jointly and severally binding

the group and each member to comply with the provisions of Title 51 RCW.

(vi) A detailed budget of all projected administrative revenues and expenses for the first year of operation.

(b) When the application for a group is tentatively approved, the applicant must submit the following:

(i) Surety, established at one hundred twenty-five percent of the standard industrial insurance premiums.

(ii) A copy of the aggregate excess insurance coverage policy.

(iii) Documentation of a contingency reserve that is the greater of:

(A) Fifteen percent of the estimated claims liability; or

(B) Twenty-five percent of the standard industrial insurance premium.

NEW SECTION

WAC 296-15-027 Additional requirements for subsidiaries and acquisitions. (1) What if an individual firm is a subsidiary of a corporation?

(a) If an individual self-insured firm has a parent (owner of fifty percent and/or having controlling financial interest), the parent must provide the department with its written guarantee, L&I form F207-040-000, to assume responsibility for all workers' compensation liabilities of the subsidiary if the subsidiary defaults on its liabilities.

(b) If a parent fails to provide a guarantee, the department will require the subsidiary to provide surety at one hundred twenty-five percent of its actual requirement. The subsidiary must continue to provide surety at the higher level as long as it has no parental guarantee.

(c) Certification of an individual self-insurer will include all of its subsidiaries (fifty percent owned and/or financial interest controlled by) or divisions doing business in Washington, as well as new acquisitions after certification becomes final. One certificate will be issued to an approved self-insurer. The subsidiaries or divisions will be considered one self-insurer for all industrial insurance purposes.

(2) What if a certified self-insurer is acquired by another entity?

(a) If it is an asset only acquisition, the certified self-insurer must surrender its certification and would retain the self-insurance liabilities and must continue to provide benefits. The new owner would be required to obtain industrial

insurance coverage through the state fund. If the new owner wishes to become self-insured, it must meet the department's minimum requirements and submit an application according to the normal certification process.

(b) If the acquisition is a stock acquisition, the new owner must either provide a parental guarantee in accordance with WAC 296-15-024(4), or if it wishes to have the self-insurance certification transferred to the new parent organization, it must:

(i) Provide proof of financial capabilities by furnishing three years of audited financial statements; and

(ii) Furnish evidence of an acceptable claim administration program to oversee a self-insurance program; and

(iii) Demonstrate the existence of an acceptable accident prevention program covering all of its operations in Washington.

AMENDATORY SECTION (Amending Order 74-38, filed 11/18/74, effective 1/1/75)

WAC 296-15-140 Expense of out-of-state audit. (~~(The audit of self-insurance plans at locations outside the state of Washington, shall be at the expense of the self insurer and the expense incurred in making such audit shall be paid by the self-insurer.~~

~~Such expenses shall be calculated at the usual and normal per diem and travel expense rates established by law and in effect at the time the expenses are incurred.))~~ (1) When is a self-insurer charged for audit expenses? The self-insurer must reimburse the department for all travel, per diem and documented expenses as related to the audit when the department representative travels outside the state of Washington.

(2) How much will the self-insurer be charged? The self-insured employer is billed the actual costs that the department incurred.

AMENDATORY SECTION (Amending WSR 99-23-107, filed 11/17/99, effective 12/27/99)

WAC 296-15-181 Funding the benefits of an insolvent self-insurer. (1) **What happens when a self-insurer defaults on (stops paying) workers' compensation benefits and assessments?** When a self-insurer stops paying workers' compensation benefits or assessments, and the default is not due to a claims administration decision, the department will take over its surety and claims. ~~((The department will manage the claims and bill the surety each quarter to reimburse benefits paid.))~~

(2) **If a defaulting self-insurer has multiple types of surety, who determines the order in which surety will be used?** The department has the sole authority to determine the order in which surety types will be used.

(3) **What happens if the defaulting self-insurer's surety is exhausted?** When surety is exhausted, the insolvency trust (all self-insurers except school districts, cities and counties) will be assessed quarterly to cover the claim costs paid on behalf of the defaulted self-insurer.

(4) **Who is on the insolvency trust board?** The insolvency trust board consists of the director or designee, three representatives of self-insured employers and one representative of workers. Representatives are nominated by the self-insured and labor communities and are appointed by the director for overlapping two year terms.

(5) **What does the insolvency trust board do?** The board advises the department on insolvency trust matters. The department makes all final decisions.

(6) **What annual report is provided on the insolvency trust fund?** The department provides an annual written status report on the insolvency trust fund as of the end of the previous calendar year to the workers' compensation advisory committee. The report is presented at the committee's first quarterly meeting no later than March 31.

NEW SECTION

WAC 296-15-266 Penalties. What must a self-insurer do when the department issues an order assessing a penalty? The self-insurer must make payment of the penalty assessment on or before the date the order becomes final.

NEW SECTION

WAC 296-15-310 Administrative organization to manage a self-insurance program. Every employer certified to self-insure is obligated to comply with the provisions of Title 51 RCW and the rules and regulations of the department, and to have the necessary administrative processes in place to manage its self-insurance program. Each self-insurer is ultimately responsible for the sure and certain delivery of Title 51 RCW benefits to its injured workers and is accountable for all aspects of its workers' compensation program.

NEW SECTION

WAC 296-15-320 Reporting of injuries. What elements must a self-insurer have in place to ensure the reporting of injuries? Every self-insurer must:

(1) Establish procedures to assist injured workers in reporting and filing claims.

(2) Immediately provide a Self-Insurer Accident Report (SIF-2) form F207-002-000 to every worker who makes a request, or upon the self-insurer's first knowledge of the existence of an industrial injury or occupational disease, whichever occurs first. Only department provided SIF-2 forms may be used. Copies or reproductions are not acceptable.

(3) Establish procedures for ensuring the timely delivery of completed SIF-2s to the claims management entity.

(4) Designate individuals as resources to address employee questions. These resources must:

(a) Have sufficient knowledge to answer routine questions; and

(b) Have responsibility for seeking answers to more complex problems; and

(c) Have detailed knowledge of the self-insurer's claim filing process; and

(d) Be reasonably accessible to employees at every work location.

(5) Maintain a claims log of all workers' compensation claims filed.

(a) For each claim, the log must consist of only the following information:

(i) The complete first and last name of the injured worker (no initials or abbreviations).

(ii) The date of injury, or for an occupational disease, the date of manifestation.

(iii) The claim number found on the department's Self-Insurer Accident Report (SIF-2, form F207-002-000).

(iv) The date the claim is closed.

(v) Whether the claim is a time loss claim or medical only.

(b) The self-insurer must designate the location of the official claims log.

(i) The self-insurer may maintain the log on its premises; or

(ii) The self-insurer may elect to have its third-party administrator maintain the claims log on its behalf. If this option is selected, there must be a written agreement between the self-insurer and the third-party administrator acknowledging that the official claims log is maintained by the third-party administrator.

The self-insurer must notify the department in writing of the location of their official claims log. If the option in (b)(ii) of this subsection is selected, a copy of the written agreement between the self-insurer and the third-party administrator must be provided to the department.

NEW SECTION

WAC 296-15-330 Authorization of medical care. What are the requirements for authorization of medical care? Every self-insurer must:

(1) Authorize treatment and pay bills in accordance with Title 51 RCW and the medical aid rules and fee schedules of the state of Washington.

(2) Provide a written explanation of benefits (EOB) to the provider, with a copy to the worker if requested, for each bill adjustment. A written explanation is not required if the

adjustment was made solely to conform to the maximum allowable fees as set by the department.

(3) Establish procedures to ensure prompt responses to inquiries regarding authorization decisions and bill adjustments.

NEW SECTION

WAC 296-15-340 Payment of compensation. What are the requirements for payment of compensation? Every self-insurer must:

(1) Pay time loss compensation in accordance with Title 51 RCW and the rules and regulations of the department.

(2) Select one method for payment of ongoing time loss compensation, either semimonthly or biweekly, and report the selected method to the department.

(3) Provide the department with a detailed written description of any practice of paying workers' regular wages in lieu of time loss compensation, or of paying workers any benefits including sick leave, health and welfare insurance benefits, or any other compensation in conjunction with time loss compensation.

NEW SECTION

WAC 296-15-350 Handling of claims. What elements must a self-insurer have in place to ensure appropriate handling of claims? Every self-insurer must:

(1) Establish procedures for securing the confidentiality of claim information.

(2) Have sufficient numbers of department-approved claims administrators to ensure uninterrupted administration of claims.

(a) There must be at least one department-approved claims administrator involved in the daily management of the employer's claims.

(b) If claims are administered in more than one location, there must be at least one department-approved claims administrator in each location where claims are managed.

(3) Designate one department-approved claims administrator as the department's primary contact person for claim issues.

(4) Designate one address for the mailing of all claims-related correspondence. The self-insurer is responsible for

forwarding documents to the appropriate location if an employer's claims are managed by more than one organization.

(5) Establish procedures to answer questions and address concerns raised by workers, providers, or the department.

(6) Ensure claims management personnel are informed of new developments in workers' compensation due to changes in statute, case law, rule, or department policy.

(7) Include the department's claim number in all claim-related communications with workers, providers, and the department.

(8) Legibly date stamp incoming correspondence, identifying both the date received and the location or entity that received it.

(9) Ensure a means of communicating with all injured workers.

NEW SECTION

WAC 296-15-360 Qualifications of personnel. How does an individual become a department-approved claims administrator?

(1) An individual must pass the department's "self-insurance claims administrator" test to be accepted as a department-approved claims administrator. In order to be admitted to take this test, an individual must meet the following requirements:

(a) Submit a completed application form to the department (Form F207-177-000). The application must be received by the department no less than forty-five days prior to the scheduled examination date.

(b) Have a minimum of three years of experience in the administration of time loss claims under Title 51 RCW. The experience must have occurred within the five years immediately prior to the filing of the application.

The department will review the application and determine if the applicant meets the minimum requirements to take the examination. Notification will be mailed to the applicant no less than fourteen days prior to the scheduled examination date.

If an applicant fails the examination, he or she must submit another completed application requesting to take the examination again. An applicant must wait six months after a failed result before retaking the examination.

(2) The designation of department-approved claims administrator is valid for five years or until an individual retakes the examination, whichever occurs first. The most recent examination results will always reflect an individual's

status as a claims administrator. To maintain approved status, an individual must:

(a) Make application as outlined in subsection (1) of this section; and

(b) Pass the "self-insurance claims administrator" examination again.

The department-approved claims administrator is responsible for notifying the department of any changes in his or her mailing address, work location, or employment status.

NEW SECTION

WAC 296-15-370 Notification to the department. When must a self-insurer notify the department about changes in its administrative organization? Any changes to the self-insurer's established administrative organization must be reported to the department in writing, within ten days of the effective date of the change.

AMENDATORY SECTION (Amending WSR 98-24-121, filed 12/2/98, effective 1/2/99)

WAC 296-15-420 After a self-insured claim is filed. (1) What must a self-insurer do when beginning time loss (TL) benefits on a claim?

~~((When beginning time loss payments, a self-insurer must:))~~

<u>When</u>	<u>Send to the worker</u>	<u>Send to the department</u>	<u>The department will</u>
((At the same time as)) On the date of the first TL payment.	A complete and accurate SIF-5 ¹ and SIF-5A ² .		
Within 5 working days of first TL payment.		Copies of the SIF-2, SIF-5, and SIF-5A.	Allow the claim UNLESS a request for interlocutory order (see subsection (2)) or denial (see subsection (3)) has been received.
If kept on salary ³ , within 5 working days of the date the first TL payment would have been due.	A complete and accurate SIF-5 and SIF-5A.	Copies of the SIF-2, SIF-5, and SIF-5A.	Allow the claim UNLESS a request for interlocutory order (see subsection (2) of this section) or denial (see subsection (3) of this section) has been received.

¹ The SIF-5 is the Self-Insurer's Report on Occupational Injury or Disease. Use a form substantially similar to L&I form F207-005-000.

² The SIF-5A is the Time Loss Calculation Rate Notice. Use a form substantially similar to L&I form F207-156-000.

³ If the worker is kept on salary, report the amount of time loss the worker would have been entitled to on the SIF-5.

(2) How must a self-insurer request an interlocutory¹ order?

When requesting an interlocutory order from the department, a self-insurer must:

<u>When</u>	<u>Send to the worker</u>	<u>Send to the department</u>	<u>The department will</u>	<u>And the self-insurer pays</u>
Within 60 ² days of claim filing.	A complete and accurate SIF-5 and SIF-5A if TL was paid <u>or if worker was kept on salary.</u>	Copies of the SIF-2, SIF-5 (with the interlocutory order box checked), SIF-5A, AND all ((medical and other pertinent information)) records <u>excluding bills</u> AND a reasonable explanation why an ((investigation)) <u>interlocutory order</u> is needed.	If it agrees, issue an interlocutory order.	Provisional TL if the worker is eligible AND other benefits as entitled. Ongoing medical treatment and vocational services are NOT PAYABLE unless the claim is allowed.
			If it disagrees, issue an allowance order if the facts show the claim should be allowed.	TL if the worker is eligible, and other entitled benefits.

¹ An interlocutory order places a claim in provisional status while the self-insurer investigates the validity of the claim.

² When not specified, time is in calendar days.

(3) How must a self-insurer request claim denial from the department?

When requesting claim denial from the department, a self-insurer must:

<u>When</u>	<u>Send to the worker</u>	<u>Send to the department</u>	<u>The department will</u>	<u>And the self-insurer pays</u>
Within 60 days of claim filing.	SIF-4,((§)) ¹ Copy to the attending or treating doctor.	SIF-4 AND all ((medical and other pertinent information supporting denial)) records <u>excluding bills.</u>	If it agrees, issue a denial order. The denial order will restate the self-insurer's right to request reimbursement of provisional TL from the worker.	For all medical evaluations and diagnostic studies used to make the determination.
			If it finds insufficient information to make a decision, issue an interlocutory order AND direct the employer to obtain the necessary information.	Provisional TL if the worker is eligible and other benefits as entitled. Ongoing medical treatment and vocational services are NOT PAYABLE unless the claim is allowed.
			If it disagrees, issue an allowance order if the facts show the claim should be allowed.	TL if the worker is eligible AND other entitled benefits.

((~~§~~))¹ The SIF-4 is the Self-Insured Employer's Notice of Denial of Claim. Use a form substantially similar to L&I form F207-163-000.

(4) What if a self-insurer does not request allowance, denial, or an interlocutory order for a claim within sixty days?

If a self-insurer does not request allowance, denial, or an interlocutory order within sixty days, the department will intervene and adjudicate the claim. The department may obtain additional medical information to make the determination. The

claim remains in provisional status until the department makes the determination.

The exception to this requirement is the allowance of medical only claims. Self-insurers are not required to request allowance for medical only claims.

(5) Must a self-insurer submit an SIF-5 each time the department requests one?

Yes. A self-insurer must submit a complete and accurate SIF-5 within ten working days of receipt of a written request from the department.

(6) What must a self-insurer do when the department requests information on a claim by certified mail?

A self-insurer must submit all requested information (~~((in its possession))~~) concerning the claim within ten working days of receipt of the department's request by certified mail.

(7) How long does a self-insurer have to provide a copy of the claim file to the worker or worker's representative?

A self-insurer must provide a copy of the claim file within fifteen days of receiving a written request from the worker or worker's representative. Unless the worker or representative requests a particular portion of the file, the self-insurer must provide a copy of the entire file.

(8) When may a self-insurer charge a worker or his/her representative for a copy of the claim file?

A self-insurer must provide the first copy of a claim file free of charge. Upon receipt of a subsequent written request, the self-insurer must provide any material not previously supplied free of charge. The self-insurer may charge the worker or any representative a reasonable fee for any material previously supplied.

(9) What must a self-insurer do when it terminates time loss ~~((because it has found the worker ineligible for vocational services))~~?

~~((Within five working days))~~ No later than the date of time loss termination, a self-insurer must notify ((the department it has found)) the worker ((ineligible for vocational services. Use an Employability Assessment Report (EAR) substantially similar to L&I form F207-121-000)) in writing of the reasons for time loss termination. If termination is based on a release to work not received directly from the worker, attach a copy of the release to the notice.

NEW SECTION

WAC 296-15-430 Vocational services. (1) When must a self-insurer submit an Employability Assessment Report (EAR) to the department?

(a) Within five working days of the date time loss benefits are terminated because the worker is not eligible for vocational services.

Note: An EAR is not required if the worker is not eligible for vocational services because they returned or were released to work at the job at time of injury.

(b) Within five working days of when the self-insurer finds the worker eligible for vocational services.

The self-insurer must use an Employability Assessment Report (EAR) substantially similar to L&I form F207-121-000.

(2) When must a self-insurer submit a vocational rehabilitation plan to the department? A self-insurer must submit a vocational plan to the department with a copy to the worker within ten calendar days after being signed by the worker, vocational rehabilitation provider, and the employer.

(3) What must the vocational rehabilitation plan include?

(a) An assessment of the worker's skills and abilities considering the worker's physical capacities and mental status, aptitudes and transferable skills gained through prior work experience, education, training and avocation;

(b) The services necessary to enable the worker to become employable in the labor market;

(c) Labor market survey supportive of the worker's employability upon plan completion;

(d) Documentation of the time and costs required for completion of the plan;

(e) A direct comparison of the worker's skills, both existing and those to be acquired through the plan, with potential types of employment to demonstrate a likelihood of plan success;

(f) A medically approved job analysis for the proposed retraining job goal;

(g) Any other information that may significantly affect the plan; and

(h) An agreement signed by the provider and worker that:

(i) Acknowledges that the provider and the worker have reviewed, understand and agree to the vocational rehabilitation plan; and

(ii) Sets forth the provider's and worker's responsibilities for the successful implementation and completion of the vocational rehabilitation plan.

The provider must use forms approved by, or substantially similar to forms used by, the department in order to document the agreement.

(4) **What is required for a formal review of the vocational rehabilitation plan?** The employer or the worker may request the department review the vocational rehabilitation plan. The reasons for the review must be stated in writing, and the request must be made prior to completion or termination of the plan.

(5) **What must the self-insurer do when the vocational rehabilitation plan is successfully completed?** The self-insurer must submit a closing report to the department within fifteen working days of terminating time loss benefits. The closing report shall contain at least the following:

(a) Documentation of the worker's successful completion of the vocational plan; and

(b) Documentation of whether or not the worker has returned to work at the time of the report.

(6) **What must the self-insurer do if the vocational rehabilitation plan is not successfully completed?** The self-insurer must either:

(a) Continue time loss benefits and submit a new or modified vocational rehabilitation plan to the department within ten calendar days after being signed by the worker, vocational rehabilitation provider, and the employer; or

(b) Within five working days of the date time loss benefits are terminated because the worker is not eligible for vocational services, submit an Eligibility Assessment Report (EAR) to the department with supporting documentation assessing the worker's employability status.

AMENDATORY SECTION (Amending WSR 98-24-121, filed 12/2/98, effective 1/2/99)

WAC 296-15-450 Closure of self-insured claims. (1) Who closes self-insured claims?

The department has the authority to close all self-insured claims. Self-insurers have the authority to close certain claims.

Within two years of claim closure, the department may require a self-insurer to pay additional benefits on a claim the self-insurer closed if the self-insurer:

(a) Made an error in benefits paid; or

(b) Violated the conditions of claim closure.

(2) **What claims may a self-insurer close?**

A self-insurer may close	If the	With time loss?	Other requirements?	With PPD?	((If a previous determinative order was issued?
Medical only (MO) claims	Claim was filed on or after ((07/26/81)) 07/01/90 and before 08/01/97	Without	None.	Without ¹	May not be closed by the employer.
Time loss (TL) claims	((Injury/illness occurred)) Claim was filed on or after 07/01/86 and before 08/01/97	With	1. Not if the department issued an order resolving a dispute; AND 2. Only if the worker returned to work with the employer of record at the same job or at a job with comparable wages and benefits. ²	Without ¹	May be closed by the employer if the order did not resolve a dispute
<u>All claims:</u> <u>Medical only (MO) claims</u> <u>Time loss (TL) claims</u> Permanent partial disability (PPD) claims	((Injury/illness occurred)) Claim was filed on or after 08/01/97	With or without	1. Not if the department issued an order resolving a dispute; AND 2. Only if the worker returned to work with the employer of record at the same job or at a job with comparable wages and benefits; ² AND 3. Only if the closing medical report was sent to the attending or treating doctor and 14 ³ days allowed for response.	With or without	May be closed by the employer if the order did not resolve a dispute.))

¹ A self-insurer may not close a claim with PPD if the injury or illness occurred before 08/01/97.

² Comparable means the wages and benefits are at least ninety-five percent of the wages and benefits received by the worker at the time of injury.

³ When not specified, time is in calendar days.

(3) When a self-insurer is closing a PPD claim, what must it do with the closing medical report?

When a self-insurer is closing a PPD claim, it must send the closing medical report to the attending or treating doctor, and the doctor must be allowed fourteen days to respond. When the attending or treating doctor responds:

Within 14 days	And the doctor AGREES with	And the doctor DISAGREES with	Then the self-insurer	
Within	Fixed and stable and PPD rating		MAY	Close the claim.
Does not respond			MAY	Close the claim
Within or before the order is issued		Fixed and stable	MUST	1. Obtain a supplemental medical opinion from (an) examiner(s) listed on the department's approved examiner's list; OR 2. Forward the claim to department for closure. The department may require additional medical examinations.
Within or before the order is issued	Fixed and stable	PPD rating	MUST	1. Obtain a supplemental medical opinion from (an) examiner(s) listed on the department's approved examiner's list; OR 2. Forward the claim to department for closure. The department may require additional medical examinations.
Not within, after the order is issued, but before the order is final		Fixed and stable and/or PPD rating	MUST	Forward the claim including the doctor's response to the department as a protest within five working days of receipt.

(4) What must a self-insurer do with a closing medical report, regardless of who is closing the claim?

A self-insurer must send the closing medical report to the attending or treating doctor. If the doctor responds that he/she does not concur with the results, the self-insurer must:

(a) Obtain a supplemental medical opinion from (an) examiner(s) listed on the department's approved examiner's list in order to do the closing action itself; OR

(b) Forward the claim to department for closure. The department may require additional medical examinations.

(5) When a self-insurer is closing a claim, what written notice must it provide to the worker and attending or treating doctor?

At claim closure, a self-insurer must send the closing order to the worker and attending or treating doctor.

(a) For a MO claim, use a Self-Insurer's Claim Closure Order and Notice substantially similar to F207-020-111.

(b) For a TL claim, use a Self-Insured Employers' Time Loss Claim Closure Order and Notice substantially similar to F207-070-000. Include a complete and accurate SIF-5 substantially similar to L&I form F207-005-000 with the worker's copy.

(c) For a PPD claim:

(i) When no TL or loss of earning power (LOEP) was paid, use a form substantially similar to L&I form F207-165-000 (MO with PPD). Include a complete and accurate SIF-5 with the worker's copy.

(ii) When TL or LOEP was paid, use a form substantially similar to L&I form F207-164-000 (TL with PPD). Include a complete and accurate SIF-5 with the worker's copy.

(6) When a self-insurer is closing a claim, what information must it submit to the department?

A self-insurer must submit to the department:

(a) MO claim closures by the end of the month following closure. These may be transferred electronically or reported by paper.

(i) Closures transferred electronically must be in the department's format.

(ii) Closures submitted in paper must include the SIF-2 L&I form F207-002-000 showing the date of closure and any vocational services provided.

(b) TL and PPD claim closures at the time of closure. Include copies of each of the following:

(i) SIF-2 if not previously submitted.

(ii) Closure order.

Note: If no one protests the self-insurer's closure order, it will become final and binding in sixty days, just like a department order.

(iii) A PPD Payment Schedule, if necessary, substantially similar to L&I form F207-162-000.

(A) A payment schedule is required when the amount of the award is more than three times the state's average monthly wage

at the date of injury. At initial/down payment, send copies to the worker and the department.

(B) The first payment of the PPD award must be paid within five working days of claim closure. Continuing payments must be paid according to the established payment schedule.

(iv) A complete and accurate SIF-5 (~~((with the Rehabilitation Outcome Report (ROR) portion completed if vocational services were provided))~~) showing all requirements for closure have been met, any TL or LOEP paid, period of payment, and total amount paid.

(7) When the department is closing a claim, what must the self-insurer submit when requesting claim closure?

When a self-insurer is asking the department to close the claim, it must submit:

(a) A complete and accurate SIF-5 (~~((with the ROR portion completed if vocational services were provided))~~); and

(b) All (~~medical and other pertinent information~~) ~~()~~ records not previously submitted to the department ~~((+))~~ excluding bills.

(8) When the department has closed a PPD claim, when must the self-insurer create a payment schedule?

When the department has closed a PPD claim, the self-insurer must create a PPD Payment Schedule substantially similar to L&I form F207-162-000 when the amount of the award is more than three times the state's average monthly wage at the date of injury. At initial/down payment, send copies to the worker and the department.

(9) When the department has closed a PPD claim, when must the self-insurer make the first payment of the award?

When the department has closed a PPD claim, the self-insurer must make the first payment of the award without delay. Continuing payments must be paid according to the established payment schedule.

NEW SECTION

WAC 296-15-470 When a worker files for reopening. When must a self-insurer forward an application to reopen a claim to the department? A self-insurer must forward an application to reopen a claim to the department within five working days of receipt.

AMENDATORY SECTION (Amending WSR 98-24-121, filed 12/2/98, effective 1/2/99)

WAC 296-15-480 ((After)) When a self-insured claim is ((closed)) protested. ((+1)) When must a self-insurer submit a worker's written protest or appeal to the department?

A self-insurer must submit a written protest ~~((or appeal))~~ by a worker to the department within five working days of receipt. The date the protest ~~((or appeal))~~ is received by the self-insurer is considered the date the protest ~~((or appeal))~~ is received by the department.

~~((+2)) **When must a self-insurer forward an application to reopen a claim to the department?**~~

~~A self insurer must forward an application to reopen a claim to the department within five working days of receipt.))~~

AMENDATORY SECTION (Amending WSR 98-24-121, filed 12/2/98, effective 1/2/99)

WAC 296-15-490 When a self-insured claim is on appeal.
(1) When must a self-insurer submit a worker's written appeal to the department? A self-insurer must submit to the department a written appeal by a worker within five working days of receipt. The date the appeal is received by the self-insurer is considered the date the appeal is received by the department.

(2) How may department orders be defended in self-insured appeals?

The department may ask the office of the attorney general to represent the department at the board of industrial insurance appeals.

~~((+2))~~ **(3) What must a self-insurer send to the department when any party appeals a claim to superior or appellate court?**

When any party appeals a claim to superior or appellate court, the self-insurer must promptly send to the department copies of the notice of appeal, judgment, and all other relevant information.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 296-15-031	Employee stock ownership plan self insurance application.
WAC 296-15-041	Joint venture self insurance application.
WAC 296-15-051	Public entity self insurance application.
WAC 296-15-061	Employer group self insurance application.
WAC 296-15-120	Log of occupational injuries and illnesses.
WAC 296-15-500	What vocational rehabilitation reports are required for self-insured employers?
WAC 296-15-510	What is the process used for vocational rehabilitation with regard to self-insured employers?